



Royal College of  
General Practitioners

# Fit for Frailty

**Part 2: Developing, commissioning and managing services  
for people living with frailty in community settings**

*Guidance for GPs, Geriatricians, Health Service managers, social service managers and  
commissioners of services*

*A report by the*  
**British Geriatrics Society and  
the Royal College of General  
Practitioners**

*in association with Age UK*

January 2015

## The British Geriatrics Society

The British Geriatrics Society is the professional body of specialists in the health care of older people in the United Kingdom. Membership is drawn from doctors, nurses, allied health professionals, scientists and others with a particular interest in the care of older people and the promotion of better health in old age. It has 3,000 members worldwide and is the only society in the UK which draws together experts from all the relevant disciplines in the field.



The BGS uses the expertise of its members to inform and influence the development of health care policy in the UK and to ensure the design, commissioning and delivery of age appropriate health services. The BGS works closely with other specialist medical societies and allies itself with age-related charities.

The BGS strives to promote better understanding of the health care needs of older people. It shares examples of best practice to ensure that older people are treated with dignity and respect and that wherever possible, older people live healthy, independent lives.

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## Royal College of General Practitioners

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As part of RCGP's commitment to improving patient care, clinical standards and GP training, the College works to shape the health care agenda in the UK and internationally. It does this by:

- Staying informed about and actively engaging with the latest developments in the rapidly changing political and health care environments
- Identifying emerging issues for the profession and where the College must take a stand
- Seeking to inform and influence decision makers about the College's stance on specific issues.

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## Fit for Frailty project

The Fit for Frailty guidance were born out of workshop meetings held at the offices of the British Geriatrics Society and AGE UK in London.

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**Dr Leila Badfael** was unable to attend the workshop but provided some background information.

Fit for Frailty Part 1 ([www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty](http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty)) provides advice and guidance on the care of older people living with frailty in community and outpatient settings and is aimed at all levels of health and social care professionals working in the community who may encounter older people living with frailty, including ambulance staff, nurses, therapists, social workers etc.

Fit for Frailty Part 2 follows on from this and provides advice and guidance on the development, commissioning and management of services for people living with frailty in community settings. It is aimed at GPs, geriatricians, Health Service managers, Social Service managers and Commissioners of Services.

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# EXECUTIVE SUMMARY

## What is Frailty?

▶ Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. Older people with frailty are at risk of unpredictable deterioration in their health resulting from minor stressor events.

## Looking for Frailty

▶ Older people should be assessed for the presence of frailty during all encounters with health and social care personnel (including reception and clerical staff).

▶ Gait speed, the timed-up-and-go test and the PRISMA questionnaire are recommended assessments for identifying frailty (full details are available in the part 1 guidance).

▶ Identifying frailty at a practice level using existing health record data is an emerging and attractive possibility.

## Managing Frailty – Services need to:

▶ Ensure all older people identified as living with frailty receive a comprehensive review of medical, functional, psychological and social needs, based on the principles of comprehensive geriatric assessment.

▶ Make available interventions for older people with frailty which improve overall physical, mental and social functioning, using a goal-orientated rather than a disease-focused approach, taking account of individual needs and personal assets, rather than deficits.

▶ Develop shared care and support plans by involving older people with frailty, their families and carers throughout all stages of the process.

▶ Remember that many people with frailty will have cognitive impairment and dementia or vice versa. Older people with dementia and frailty will have especially complex care needs, requiring a judicious approach to care planning.

▶ Consider end of life care planning for older people with frailty if there is evidence of declining ADL function, unstable long-term conditions, advancing dementia or systemic features indicating severe frailty, including weight loss and severe exhaustion.

▶ Be fully integrated across health and social care systems, because those with frailty stand to gain most through an integrated approach. Likewise, a service which addresses the whole pathway across primary care, community care including social care and secondary care is likely to be the most successful.

▶ Establish joint working between primary care, ambulance service, community teams, geriatricians and old age psychiatrists to attend to the complex medical, functional, social and psychological aspects of frailty more effectively.

▶ Signpost older people with frailty to relevant local authority, domiciliary care and voluntary sector services.

- ▶ Recognise that most of the long-term care and support for those with frailty is provided by family, friends and private carers. Ensure that these people are identified, supported and networked into the primary care and community team.
- ▶ Provide real and safe alternatives to hospital admission when an older person with frailty is unwell, recognising the potential health risks of hospitalisation.
- ▶ When hospital admission is clinically appropriate, overcome historical barriers between health and social care to develop pathways to pull older people with frailty out of hospital and prevent unacceptable delayed transfers of care.

## **Managing Services – Training and Education**

- ▶ Develop local training and education packages structured around the application of comprehensive geriatric assessment in frailty for multi-professional teams working in primary, community, intermediate care and secondary care to maximise the sharing of skills.

## **Managing Services - Evaluation**

- ▶ Consider process measures including waiting time to be seen for comprehensive geriatric assessment and delayed transfers of care from hospital when developing and evaluating frailty interventions.
- ▶ Consider self-reported outcome and experience measures that are relevant for older people with frailty when developing and evaluating frailty services, including quality of life, loneliness, pain, function and harms (e.g. falls, adverse medication events).
- ▶ Consider outcomes that are relevant for local health services, including reduction in excess bed days, reduction in outpatient visits, reduction in primary care consultations, patient safety and improved staff recruitment and retention.
- ▶ Remember that desired outcomes such as reduced unplanned admissions and reduction in health and social care costs may take time to achieve and are unlikely to be seen in the immediate aftermath of a service or structural change. These outcomes are also unlikely unless there has been a change in working practice at scale (demonstrated through the process measures outlined above).

## **Commissioning and Developing Services**

- ▶ Structural changes may help develop new models of proactive, person centred care for older people with frailty. These include General Practice Federations, within general practice and new models of funding and commissioning, including joint health and social care commissioning and whole systems frameworks within secondary and community care. All these changes will need a workforce which is flexible in working across boundaries and interfaces and which challenge traditional training pathways.
- ▶ It is essential that all services are bound together within some form of integrated contractual framework since commissioning for community services in isolation is unlikely to be effective. This means that in England, commissioners need to consider new models of collaborative commissioning, working with providers rather than being too reliant on market solutions.



## Why services for frailty are important

### 1.1 Introduction

The purpose of Fit for Frailty Part 2 is to provide advice and guidance on the development, commissioning and management of services for people living with frailty in community settings. The audience for this guidance comprises GPs, geriatricians, Health Service managers, Social Service managers and Commissioners of Services. Fit for Frailty Part 2 is a companion report to an earlier BGS publication, Fit for Frailty Part 1 which provided advice and guidance on the care of older people living with frailty in community and outpatient settings ([www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty](http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty)).

***Like diabetes or Alzheimer's disease, frailty is a long-term condition. An individual's degree of frailty is not static. It may be made better or worse, depending on the care received when an individual presents to a health professional.***

***An apparently small event, for example a minor infection, a new medication, or constipation, may trigger a dramatic change in the physical or mental wellbeing of an individual with frailty. If the presence of frailty has been identified, this will influence the health or social care professional in weighing the benefits and risks of any intervention or treatment plan.***

There are three main sections in Fit for Frailty Part 2. The first section introduces the concept of frailty and sets out the rationale for developing frailty services. The second section explores the essential characteristics of a good frailty service. The third section considers the issue of performance and outcome measures for frailty services. The appendix to the report includes eight case studies of frailty services which are operating in different parts of the UK.

### 1.2 What is frailty and why is it important?

Frailty is a clinically recognised state of increased vulnerability among older adults. It is associated with a decline in an individual's physical and psychological reserves. Though frailty results from ageing, it is not an inevitable part of ageing. Like diabetes or Alzheimer's disease, frailty is a long-term condition. An individual's degree of frailty is not static. It may be made better or worse, depending on the care received when an individual presents to a health professional.

The recognition of frailty is important and this is why assessment for frailty should form part of any interaction between an older person and a health or social care professional. An apparently small event, for example a minor infection, a new medication, or constipation, may trigger a dramatic change in the physical or mental wellbeing of an individual with frailty. If the presence of frailty has been identified, this will influence the health or social care professional in weighing the benefits and risks of any intervention or treatment plan. If frailty goes unrecognised, the adverse consequences for the health and wellbeing of the older person may be severe.

Currently frailty is often not recognised until a person presents in crisis, for example, following a significant fall. This may then lead to hospital admission, an event which in itself may trigger worse outcomes for someone who is frail.<sup>[1]</sup>

There are five recognised frailty syndromes and the presence of one or more of these should raise suspicions that the individual has frailty and that an apparently simple presentation may mask a more serious underlying condition. The syndromes are:

- ▶ Falls (e.g. collapse, legs give way, found lying on the floor)
- ▶ Immobility (e.g. sudden change in mobility, gone off legs, stuck on toilet)
- ▶ Delirium (e.g. acute confusion, worsening of pre-existing confusion/short-term memory loss)
- ▶ Incontinence (e.g. new onset or worsening of urinary or faecal incontinence)
- ▶ Susceptibility to side effects of medication (e.g. confusion with codeine, hypotension with antidepressants) ([www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty](http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty))

### 1.3 Frailty, long-term conditions and disability

It is important to understand the difference between frailty, long term conditions (LTCs) and disability. Many people with multiple long term conditions (so called multi-morbidity) will also have frailty. This may be masked when the focus is on other disease-based LTCs. Likewise, some people whose only LTC is frailty may not be frequent users of health services. Indeed, they may not become well-known to their GP until they become bedbound, immobile or delirious as a result of an apparently minor illness. Though there may be overlap between the management approaches for people with multi-morbidity and those with frailty, these conditions are not identical. The guidance in this report looks primarily at frailty.

Similarly, there is overlap between frailty and physical disability. Many people with frailty also have disability. Equally there are many people with a long term disability who do not have frailty. Frailty may be the cause of disability in some patients and the consequence in others.

### 1.4 Issues of language and perception

The language of frailty can act as a barrier to engaging with older people who may not perceive themselves as frail, or who may not wish to be defined by a term that is often associated with increased vulnerability and dependency. Older individuals may not identify themselves as living with frailty and there is evidence that older people do not want to be considered as 'frail', although they may be happy to accept that they are older persons.<sup>[1]</sup> For an older person, living with frailty can mean living with various 'losses' and it is easy, as a professional, inadvertently to collude with the loss of control over everyday life that results from an extensive care package, social isolation or the rapid change in mental state that sometimes accompanies frailty. Research has demonstrated that many older

***[Some people with frailty] may not become well-known to their GP until they become bedbound, immobile or delirious as a result of an apparently minor illness.***



**Research has demonstrated that many older people living with frailty develop ways of coping and make other compensatory choices.**

people living with frailty develop ways of coping and make other compensatory choices.<sup>[2]</sup>

As a group, ‘older people with frailty’ encompass a diversity of individuals, each with different expectations, hopes, fears, strengths and abilities, as well as different types and levels of need and support. It is the job of clinicians and service providers to ensure that individual differences are, as far as is possible, accommodated, thus restoring control, preserving dignity and facilitating person-centred care to the older person living with frailty and those close to them.

## **1.5 Why do we need special services for frailty?**

The reasons for providing special services for frailty are considered here under two broad headings: clinical and quality reasons; and political imperatives.

### **1.5.1 Clinical and quality reasons**

Older people are the main users of health and social care services. Approximately 10 per cent of people aged over 65 and 25 – 50 per cent of those aged over 85 are living with frailty. Research suggests that only half of older people with frailty syndromes receive effective health care interventions.<sup>[3]</sup> There is a risk of significant harm to patients with frailty if health interventions are planned for them in the absence of recognition of their frailty. Interventions that may trigger adverse outcomes in these circumstances include: starting a new drug, conveying the patient to the emergency department, or undertaking an elective joint replacement. There is some evidence that focusing community services on those with frailty rather than on those ‘at highest risk of hospital admission’ might improve quality of patient care and reduce hospital bed usage.

**There is a risk of significant harm to patients with frailty if health interventions are planned for them in the absence of recognition of their frailty.**

Older people with frailty have been the victims of many of the quality failings in health and social care over the last five years, for example at Mid Staffordshire NHS Foundation Trust. These were problems which might have been avoided had patients’ frailty and concomitant complex needs been identified and appropriate management plans put in place.

The blueprint for excellence in care for older people with frailty is exactly the same as the blueprint for high quality and safe care for all users of the health services.<sup>[4]</sup>

### **1.5.2 Political imperatives**

- ▶ Frailty is a Long Term Condition and the NHS Outcomes Framework in England requires improved management of Long Term Conditions.
- ▶ Transforming Primary Care policy (NHS England 2014 and the Department of Health) calls for safe personalised and proactive out of hospital care for those with the most complex needs and aims to drive up the quality of care for older people.<sup>[5]</sup>

- ▶ The Care Act (2014) requires a preventative approach to the management of older people.
- ▶ Frailty services fit with the aspirations of the planned Health and Social Care Bill in Wales, calling for increased integration of Health and Social Services.
- ▶ There has been political and financial support for initiatives in Wales such as the Gwent Frailty Project and the Wrexham Frailty Project at Glyndwr University.
- ▶ The Reshaping Care for Older People programme in Scotland focuses on prevention and promotion of independence in older people, including developing effective pathways of care for older people with frailty.<sup>[6]</sup>
- ▶ The recently published Five-Year Forward View indicates that the NHS will provide more support for frail older people living in care homes and that “primary care of the future will build on the traditional strengths of ‘expert generalists’, proactively targeting services at registered patients with complex ongoing needs such as the frail elderly or those with chronic conditions, and working much more intensively with these patients”.<sup>[36]</sup>

## 1.6 What is the relationship between services for frailty and services for dementia?

### 1.6.1 Clinical relationship between frailty and dementia

***Although it is possible to have dementia in the absence of frailty and frailty in the absence of dementia, frailty is strongly associated with cognitive impairment and clinically diagnosed dementia among persons aged 76 and older. Physical frailty is also associated with low cognitive performance.***

- ▶ Frailty is a multi-dimensional syndrome which may include physical, psychological, cognitive and social impairment.
- ▶ Although it is possible to have dementia in the absence of frailty and frailty in the absence of dementia, there is a large area of overlap between the two conditions. Dementia contributes to frailty and physical frailty contributes to cognitive impairment and dementia.
- ▶ A recent study confirmed that frailty is strongly associated with cognitive impairment and clinically diagnosed dementia among persons aged 76 and older. Physical frailty is also associated with low cognitive performance.<sup>[8,9]</sup>
- ▶ The concept of cognitive frailty has been proposed recently, combining physical frailty with cognitive impairment in the absence of a full dementia syndrome. It is suggested that it is important to identify cognitive frailty since there may be a component of reversibility within the multi-dimensional approach to frailty.<sup>[10]</sup>
- ▶ In designing services for frailty and dementia, it is important to consider the evidence that carers of people with dementia - may themselves have a higher risk of frailty.<sup>[11]</sup>

### 1.6.2 Design of services

▶ Service design must ensure that the assessment and management of frailty includes assessment of cognitive impairment and dementia; and also that assessment and management of dementia includes an understanding of the overlap between dementia, cognitive impairment and frailty.

▶ It is important that the overlap between dementia, cognitive impairment and frailty is considered in national strategic planning. Although the Dementia Strategies in England and Scotland, and the Dementia Vision in Wales, address the need for personalised care and a multidimensional approach, none acknowledges directly, the relationship with frailty in people living with dementia.<sup>[12][13][14]</sup>

▶ Strategic priorities for dementia in the three nations include improving diagnosis, improving services to make them dementia friendly, supporting dementia friendly communities and promoting research into dementia.

Additional priorities for dementia include improving service provision through better joint working across health care, social services, the third sector and with other agencies. Priorities should also acknowledge the importance of the overlap between dementia and frailty. Efforts to improve early diagnosis and intervention should include an awareness that frailty can contribute to cognitive impairment and dementia.

▶ Evidence shows that the risk factors for frailty are also risk factors for dementia.<sup>[15]</sup> This means that a health promotion and preventative approach may impact on population health in both domains.

▶ Joint working is particularly important for those with frailty and dementia. Improving information availability, advocacy and training for those delivering care should also include better information and training on the links between frailty and cognitive impairment and dementia.

▶ Closer working between a range of services - Older People's Mental Health Teams or memory services, Care of the Elderly services, primary care and social services - is particularly important for those with dementia and frailty. Services should be designed to accommodate closer working or even integration of Older People's Mental Health Teams and Care of the Elderly services (See Section 2.5.4).

***Evidence shows that the risk factors for frailty are also risk factors for dementia. This means that a health promotion and preventative approach may impact on population health in both domains.***

### What will good services for frailty look like?

#### 2.1 Introduction to good services for frailty

This section of Fit for Frailty 2 sets out the premises upon which all interventions for frailty should be based.

It also identifies and discusses the six essential characteristics of a good service for frailty. These are:

- ▶ effective recognition, diagnosis and referral for frailty;
- ▶ a person-centred ethos and practice;
- ▶ integration of care in multiple settings;
- ▶ expertise of staff;
- ▶ practice underpinned by comprehensive geriatric assessment and care planning; and
- ▶ use of tools to assist case-finding.

#### 2.2 Premises underpinning frailty services

All health and social care services need to ensure the delivery of interventions for frailty and these interventions should be based upon the following premises.<sup>[7]</sup>

- ▶ Frailty can be improved but treatment and intervention needs to be individualised.
- ▶ Intervention is aimed at improving physical, mental and social functioning to avoid adverse events, for example, injury, hospitalisation, institutionalisation. This contrasts with the strictly disease-orientated biomedical approach taken to many other long-term conditions.
- ▶ Support will need to be sustained over a long time and will need to continue even through intervening crises and adverse events.
- ▶ As far as possible, the intervention plan must enable the participation of the older person with frailty.
- ▶ There must also be engagement with the family and/ or carers whose needs should also be considered.

***Intervention is aimed at improving physical, mental and social functioning to avoid adverse events, for example, injury, hospitalisation, institutionalisation. This contrasts with the strictly disease-orientated biomedical approach taken to many other long-term conditions.***

#### 2.3 Effective recognition, diagnosis and referral for frailty

##### 2.3.1 Recognition and diagnosis of frailty

The key to a good service for frailty is the capacity of health and social care staff to recognise frailty. GPs are best placed to coordinate the identification of older people with frailty, to perform the initial medical review based on the principles of comprehensive geriatric assessment, and to refer patients

onwards for further care as appropriate. Ideally, GPs should have access to well-designed pathways to integrated health and social care teams. Specific opportunities for GPs to identify frailty also arise when following up individuals after hospital discharge within the parameters of formal audit for Avoiding Unplanned Admissions (AUA) DES. <sup>[footnote 1]</sup> Opportunities also arise when doing medicines reconciliation for those not under the DES.

**Outreach models with community geriatricians provide a powerful mechanism for supporting GPs in the management of individual cases. This model is especially effective when deployed in contexts where there are multi-disciplinary team meetings providing a forum for team discussion and peer learning. GP federations can also provide a very effective infrastructure to enable this kind of case based peer learning for both clinical and non-clinical teams.**

### **2.3.2 Referral following diagnosis of frailty**

When frailty is suspected, the next step may be referral by a GP to a specialist community service for full comprehensive geriatric assessment. Outreach models with community geriatricians provide a powerful mechanism for supporting GPs in the management of individual cases. This model is especially effective when deployed in contexts where there are multi-disciplinary team meetings providing a forum for team discussion and peer learning. GP federations can also provide a very effective infrastructure to enable this kind of case based peer learning for both clinical and non-clinical teams.

Not everyone with a diagnosis of frailty will need a referral to a specialist team. GPs will be providing palliative care to some patients in their own homes or in care homes. There, the application of advance care planning will be as applicable in the case of frailty as it is in the case of other diagnoses such as cancer. On the other end of the spectrum, individuals with less severe frailty may benefit from group-based exercise or other activity programmes. GPs are the gatekeepers and decision-makers in terms of referral pathways for patients with frailty.

Systematic identification and recording of data on patients with frailty would facilitate better modelling of need, service planning and clinical management within the primary care system.

**“The RCGP strongly supports giving GPs the opportunity to lead a transformation of care for vulnerable older people in the community. We know that these patients, who are more likely to be living with multiple long term conditions, need care which goes beyond the standard ten minute consultation. They need proactive care from an expert generalist able to take the time to properly assess their needs holistically, combined with proactive support from a multi-disciplinary team.”**

**Dr Maureen Baker RCGP**  
[www.kingsfund.org.uk/sites/files/kf/field](http://www.kingsfund.org.uk/sites/files/kf/field)

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<sup>1</sup>The Avoiding Unplanned Admissions (AUA) DES recognises a need to fund a proactive role for general practice in the integration of care for high risk individuals, which certainly encompasses those with frailty. However currently the entry criteria for this DES do not target care for this group.

## 2.4 Person-centred ethos

The ethos of a good frailty service is person-centred. Frailty provides a conceptual basis for moving away from organ and disease-related medical approaches towards a more integrated, holistic and person-centred model of care. This fits well with the biopsychosocial generalist model which is a cornerstone of General Practice.

Currently, the RCGP is actively working with the Coalition for Collaborative Care to develop a proactive GP service offering, as part of a new model of person-centred, co-ordinated care which takes a holistic, biopsychosocial approach. The starting point for this new model is what is important to the individual with frailty, their family and carers. As its name implies, a person-centred coordinated care and support planning process is aimed at the individual and their carers/ family, ensuring that their preferences are built upon and inform professionally owned plans of care.

The 'I' statements in Figure 1 below describe what this experience should feel like for the person on the receiving end.

<b>Independence</b>	<ul style="list-style-type: none"> <li>• I am recognised for what I can do rather than making assumptions about what I cannot</li> <li>• I am supported to be independent</li> <li>• I can do activities that are important to me</li> <li>• Where appropriate, my family are recognised as being key to my independence and quality of life</li> </ul>
<b>Community interactions</b>	<ul style="list-style-type: none"> <li>• I can maintain social contact as much as I want</li> </ul>
<b>Decision making</b>	<ul style="list-style-type: none"> <li>• I can make my own decisions, with advice and support from family, friends or professionals if I want it</li> </ul>
<b>Decision making</b>	<ul style="list-style-type: none"> <li>• I can build relationships with people who support me</li> <li>• I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me</li> <li>• Taken together, my care and support help me live the life I want to the best of my ability</li> </ul>

Figure 1 'I' Statements for Older People [16]

The process also considers the needs and wishes of family and carers and the resources available to the person living with frailty in their community.

## 2.5 Integrated and holistic care

Among the most important determinants of good, patient-centred care are continuity of care and care integration.<sup>[17]</sup>



The BGS and RCGP fully support initiatives to move to integrated care but this must be manifest in practical outputs including:

- ▶ Sharing of patient Information between health professionals
- ▶ Trusted and shared assessments
- ▶ Continuity of care which is personalised
- ▶ A single points of access for all services <sup>(footnote 2)</sup>

### **2.5.1 Integration in primary care**

Identification of individuals with frailty will allow for better planning and modelling of need at the level of General Practice. As described above, care centred holistically around the person and relevant carers can be a powerful way of reorganising services, ensuring co-operation among providers, driving teamwork across organisational boundaries and engaging with community assets and resources.

***Once an individual is identified as having frailty, they are likely to benefit from a service model based around ongoing proactive person-centred, co-ordinated care via care and support planning. This delivers repeated planning cycles consisting of a preparation phase for processes of care e.g. questionnaires, blood tests and checks (whether health care assisted or self administered), a holistic medical review, including a medication review, and a care planning discussion with the individual (and their carers, as appropriate) likely to take between 30 – 60 minutes.***

Frailty, especially with cognitive impairment, identifies people who may need longer for the provision and assimilation of information, especially in clinical settings. People with frailty are likely to have complex care needs with multiple, interacting clinical problems. We would argue that once an individual is identified as having frailty, they are likely to benefit from a service model based around ongoing proactive person-centred, co-ordinated care via care and support planning. This delivers repeated planning cycles consisting of a preparation phase for processes of care e.g. questionnaires, blood tests and checks (whether health care assisted or self administered), a holistic medical review, including a medication review, and a care planning discussion with the individual (and their carers, as appropriate) likely to take between 30 – 60 minutes. The underpinning aim is to improve self-management of the person and of their relevant family/carers in order to optimise their health and wellbeing by improving their knowledge, skills and confidence.

Continuity is an important aspect of patient-centred care and is particularly important with frailty because of the challenging complexity associated with this condition. There is a need for General Practice culture to ensure that an individual with frailty is managed by the same GP on all occasions, where possible. There is evidence that older patients are willing to wait longer to see the doctor who knows them best. <sup>[19]</sup> This is different from the current practice of having a named GP which does not necessarily guarantee continuity.

GP federations could enable practices working together in their community to develop new roles such as care navigators, integrated nursing teams and dedicated roles to support frailty management (see Section 3.3.2 for more detail).

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<sup>2</sup> An extensive review by the Kings Fund considers all aspects of service integration for older people with frailty along the whole pathway of care. The reader is urged to consult this review for detailed information.<sup>[18]</sup>

### **2.5.2 Integration in community and intermediate care**

We have highlighted the benefits of early warning flagging for people who may have frailty across the whole of the health and social care system and of early GP based holistic assessment and review. However these can only improve outcomes if there are appropriate community and intermediate care services in place to support General Practice teams.

The key components of good community services are:

**Accessible and coordinated care** which can be navigated easily either by the individual or a dedicated system navigator on behalf of the individual. Care is accessed through a single point and a single health or social care practitioner is available who is responsible for the organisation of services for an individual with frailty. This practitioner acts as a point of contact for support and help.

**Timely and compassionate care** which is responsive to the health needs of the individual, both in care of long term chronic conditions and also when crisis occurs. Both are vital components of community and intermediate care services and one should not take precedence over the other.

**Continuity of care** which, for an older person with frailty interacting with community health and social services, means proper and full information sharing between healthcare and social care professionals working in any sector generally in real time. Thus adequate attention needs to be given to common assessment frameworks, shared and trusted assessment plans and of course an IT infrastructure to facilitate shared assessment. This is all needed for a truly integrated approach to health care delivery.

**Person centred, goal-orientated care** which means that assessment is based on assets and strengths, not deficits. This will facilitate the identification of personal goals. Provision of health and social care and support should be organised to enable an individual to achieve their own goal(s). These may not be centred around the management of a specific disease or the achievement of disease-based outcomes (such as keeping blood sugar levels at a specific level) but instead focus on the priorities of the service user. Sometimes the goals will contradict medical goals; for example patients with high blood pressure may want to forego treatments which make them hypotensive at times and thus liable to fall or feel dizzy. Understanding an individual's goals and planning treatment and support strategies to achieve those goals involves the process of care planning (see Section 2.7.2).

If General Practice becomes able to deliver person-centred care and support planning, then the wider integrated team should be able to pick up and expand on the planning that has gone before. This will ensure a continuous process centred around the patient. It is important to develop effective methods for sharing these planning outputs with the person concerned, their family/ carers as appropriate and with the core GP-based proactive service.

### **2.5.3 Integrated care and care homes**

Nearly 400,000 older people live in UK care homes and nearly 20 per cent of those are aged over 85. Their health and social care needs are complex. All have some disability,

almost all have frailty, many have dementia, and collectively they have high rates of both necessary and avoidable hospital admission. Standard healthcare provision meets their needs poorly, but well-tailored services can make a significant difference to their wellbeing. The most effective models of care for residents of care homes incorporate care planning, multi-professional interventions and an integral role for the staff of care homes. The BGS has published guidance for commissioning healthcare services for care. This details the problems faced by residents of care homes and the potential service models to address those issues <sup>[26]</sup> <http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/commissioning2013>].

#### **2.5.4 Integrated care and mental health**

Much of the discussion about integration and co-ordination of health services for older people with frailty is focused on the interfaces between acute and community care, and health and social care. Yet there is considerable potential for synergy and patient benefit when the interface between physical and mental health services for older people is actively managed to reduce barriers.

The skills required by Geriatricians and Old Age Psychiatrists are very similar when dealing with frailty and the use of the Care Programme Approach (CPA) in older people's mental health teams (OPMHT) mirrors closely the facets of comprehensive geriatric assessment. The only difference is that the former is enshrined in law in England. In Wales the CPA has been superseded by part 2 of the Mental Health Measure with Local Health Boards and Local Authorities having joint responsibility for implementation [<http://www.mentalhealthwales.net/mhw/care.php>].

In practical terms a managed interface between services could take a number of forms. At one end of the scale, there may be full integration of the OPMHT into the community and primary care teams with patients being seen by the most appropriate member of the combined team. At the other end, there may be a carefully structured process which ensures that the expertise of both teams is available to all patients regardless of the team to which they first present. In other words, memory clinics and OPMHT must be aware that cognitive decline can be accompanied by other aspects of frailty. Clinic staff should actively search for frailty using Gait Speed and TUGT (see Fit for Frailty Part 1 for more detail) and make the appropriate onward referral. Likewise, community and primary care teams should be actively looking for mental health problems and there needs to be clearly defined pathways which facilitate access to mental health expertise.

#### **2.5.5 Integrated care, ambulance and community emergency services**

For many older people with frailty, the first point of contact with the health service is the ambulance service during a crisis. The crisis could be a fall, delirium or sudden immobility. Previous research has shown that ambulance crews - (in particular Emergency Care Practitioners (ECPs) - can effectively review older people in the community after a fall and with breathing difficulties, thus reducing both attendance at Emergency Departments (ED) and Inpatient stays<sup>[20, 21]</sup>. However, ambulance crews need training to recognise frailty and incorporate an understanding of varying levels of frailty in their responses to patients when managing crises.

The ambulance service currently operates separately from the primary care and community care teams. They are one of the few services in the community to operate 24/7 and it would seem appropriate for them to be much more closely aligned with the teams who know and work with older people with frailty in a locality. They could then provide an early warning to those teams when their patients have had a health crisis. In some areas of the country, joint working between the ambulance and community services has meant that shared care of older people with falls and other frailty syndromes has been set up with specialist ambulances (See Appendix 1, Case Study 8, The AGIS Service in Cambridgeshire).

In addition, the sharing of information with ambulance crews about older people with frailty, known to the primary and community care teams, would enable better management of individuals in accordance with agreed plans.

### **2.5.6 Social Services and domiciliary care**

Older people with frailty are the main users of adult social care services. Routine identification of frailty as part of the initial assessment would help staff to signpost patients to relevant services and ensure that they access the locally determined pathways for holistic medical assessment and/or multi-professional assessment as part of a comprehensive geriatric assessment (CGA).

Initial assessment of a person with frailty should not depend on whether that individual is eligible for social services funding. In many cases where there is good integrated care, a social care assessment may form part of the comprehensive geriatric assessment.

Most of the long term personal care and support for older people with frailty living in the community is delivered by either family and or friends and private carers provided by commercial firms and agencies (and often paid for by older people themselves) or in private care homes. It is therefore vital that these staff are networked into the local primary and community care teams and services as it is frequently they who will deliver the interventions identified as part of the holistic medical review or CGA. This may mean joint learning events for privately and publicly employed staff. It is recognised this is a potentially sensitive area and there are commercial issues to be considered. Nevertheless, for the benefit of an individual with frailty, these staff must be considered as much part of the multi-disciplinary teams as the family and friends of the person with frailty.

As local primary and community services become more successful in identifying frailty and developing individualised proactive care and support plans, it is anticipated that there will be a greater involvement of social services at an earlier stage in a frailty pathway. This is in keeping with the expectations of the Care Act 2014. In some parts of the country, the identification of frailty either involves a third (voluntary) sector organisation or will lead to involvement of a third sector partner as part of the intervention agreed during the care planning process (See Appendix 1, Case Study 1, Warwickshire Age UK-EASYCare Approach and Case Study 6, Age UK Volunteers promote participation in Cheshire).

The main challenge to older people with frailty is the risk of adverse outcomes which can occur with a relatively minor insult to the social stability of the person. Social services and community teams should be orientated to help avoid these outcomes by challenging historical ways of working so that they provide real alternatives to hospital admission when someone is ill. They also need to work together to pull someone out of hospital after the acute phase of care is over. No long term care planning should take place while an individual is a patient in an acute hospital.

### **2.5.7 Integrated care and end of life care**

People can be supported to live with frailty for many years. However, frailty has been reported to be the most common condition leading to death in older people.<sup>[22]</sup> Nonetheless, advanced care planning and end of life care are not yet well established for those with frailty. Older people with frailty do not follow a particular pattern of decline in the final year of life. Some have no disability; others have gradually progressive disability; some develop sudden and major disability. The Gold Standards Framework Prognostic Indicator guidance includes information on how to identify older people with frailty who might be nearing the end of life. See (<http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf>). The BGS and RCGP recommend consideration of end of life care planning for older people with frailty if there is evidence of declining ADL function, unstable long-term conditions (e.g. heart failure or COPD with regular exacerbations), advancing dementia or systemic features indicating severe frailty including weight loss and severe exhaustion.

## **2.6 Staff expertise**

It is vital that the members of multi-professional teams working in primary, community and intermediate care teams have specialist expertise in the management of older people with frailty so as to be able to deliver the interventions which form part of a comprehensive geriatric assessment (See Section 2.7.1). Joint training, education and development within community settings around localities are urgently needed so as to build a set of core competencies among staff teams. This could require a restructuring of the existing training and education silos and the development of imaginative programmes of structured learning (See Appendix 1, Case Study 7, Educating a Frailty Medical Workforce in the New Forest).

In addition, it is vital to ensure that older people with other conditions besides frailty can still access appropriate expertise from within community settings – for example, specialist stroke therapy, support for Parkinson’s disease, gait analysis and therapeutic techniques. Pain services need to be widely available in community settings as opposed to being accessible only through long outpatient waiting lists.

The Future Hospitals Commission recognises the need for expertise to move outside of hospitals to facilitate whole systems integrated working and the redesign of services to provide more services in the community, provided by generalist and specialists working together as part of multi-disciplinary teams.<sup>[23]</sup>



## 2.7 Practice underpinned by comprehensive geriatric assessment (CGA) and care planning

Two key elements of evidence-based practice in the care of patients with frailty are described here, *viz.* comprehensive geriatric assessment and care planning.

### 2.7.1 Comprehensive Geriatric Assessment

The gold standard for the management of frailty in older people is the process of care known as comprehensive geriatric assessment (CGA). It involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings.<sup>[25, 26]</sup>

CGA is a clinical management strategy which will give a framework for the delivery of interventions addressing relevant issues for a particular patient. Only after the completion of CGA is it possible to use the Rockwood Clinical Frailty index to identify the level of frailty of the individual.<sup>[27]</sup>

However, CGA is not a rapid process. The initial assessment and care planning for a full CGA is likely to take at least 1.5 hours of professional time, plus the necessary time for care plan negotiation and documentation. The likely total is 2.5 hours. There is also a need to factor in additional time for ongoing review.

It is therefore simply not feasible for everyone with frailty (from mild up to severe life limiting frailty) to undergo a full multidisciplinary review with geriatrician involvement. However all patients with frailty will benefit from a holistic medical review (see detail in Fit for Frailty Part 1) based on the principles of CGA. Some people will need to be referred to a Geriatrician for support with diagnosis, intervention or care planning, and others will also need to be referred to other specialists in the community such as an Old Age Psychiatrists, therapists, specialist nurses, dieticians and podiatrists.<sup>[footnote 3]</sup>

Whatever level of input is needed for an individual, the resulting process of assessment, individual care and support planning and regular review is vital to provide an evidence-based management plan for frailty.

### 2.7.2 Comprehensive care planning

Comprehensive care planning is another component of good community care for frailty and this is not just about producing a piece of paper. Guidance for good care planning is available.<sup>[28]</sup> Essentially it entails an individual expressing their thoughts through a structured narrative. This allows the patient to frame their wishes and needs or objectives in their own terms. A period of reflection should then be allowed before the formulation of the care plan. Properly done, the process will enable significant patient (and carer) engagement and the development of a highly individualised plan of care. However, it is a procedure which requires skill and time. Thus good primary and

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<sup>3</sup> In terms of the prevention of frailty, NICE guidance is currently being developed to advise on mid-life strategies to help people improve their health and reduce the risk of frailty in later life. In addition, public health strategies are needed to promote activity and adequate nutrition which can address and reverse frailty.<sup>[24]</sup>



community services will need to build this process into their systems. (See Part 1 of the guidance). Much of the output of a holistic medical review based on CGA principles will be in the form of individualised care and support plans (CSP). The same format for a CSP will be used whether or not the individual is managed within primary care or referred to specialist services for a full CGA.

There will be common elements in individualised Care and Support plans as shown in Figure 2 below.

**The named individual** who is responsible for coordinating care on behalf of the patient who will be the patient's main point of contact in the community teams. For someone who has not been referred to the community teams and who has had a holistic medical review by their GP, it is likely that their GP will be the named individual.

**A health and social care summary** (including symptoms, underlying diagnoses, medications and current social situation)

**A Wellbeing maintenance plan** which includes:

- What the individual's goals are
- What the actions are that are going to be taken
- Who is responsible for doing what (including the patient, their carers, their relatives, the doctor and other health professionals )
- What the timescale is and how and when review will happen

**An escalation plan** which describes:

- What a patient and or their carer might need to look out for
- Who to call or what to do if there is a problem

**An urgent care plan** – which summarises what the individual wants to happen if a crisis occurs in either their own health ( i.e. do they want to go to hospital, under what circumstances would they want to stay at home, whether there is a DNACPR order in place) or in the health of their carer. This carer's emergency plan can sometimes be facilitated in advance by the Princess Royal Trust for Carers ([www.carers.org](http://www.carers.org)) who will visit the patient and their carers to discuss contingency plans.

For some patients it will also be appropriate to have in place;

**An advance care plan or end of life care plan** – which could describe the patient's wishes with respect to their preferred place of dying and whether they have 'just in case' medications in place.

## 2.8 Use of tools to assist case-finding

### 2.8.1 Tools for identifying frailty

In Fit for Frailty Part 1, we considered a range of tools for identifying older people with possible frailty across a range of routine settings such as during contact with social services or a GP. We recommended the use of three tools in particular for this purpose. These were the PRISMA-7 questionnaire, gait speed and a Timed Up and Go test (TUGT) [<http://www.bgs.org.uk/index.php/resources-6/bgscampaigns/fit-for-frailty>]. Such tools are sensitive for frailty but not specific to frailty, so positive results should be checked in a second stage, such as through a clinical assessment.

With regard to gait, slow gait speed i.e. taking more than 4 seconds to walk 5 meters, even with an aid, may be an indicator of frailty. Observing gait in corridors and reception areas, previously marked up with 4m markers, could easily highlight people who might need further review. Other methods of case-finding are discussed in Section 2.8.2 below and also in Appendix 1 (See Case Study 2, the Gnosall Birthday Card Project).

Older people coming into contact with health and social care services, particularly those presenting with one of the frailty syndromes (such as falls or immobility) may well already have established frailty. There is considerable interest in how we could identify those individuals with early frailty who might benefit from intervention to prevent further deterioration of function. Much of the research in this area has focused on primary care, either using the type of simple assessments mentioned above, or using automated screening of patients' records.

As yet there is no consensus as to the most appropriate target group for intervention, although it has been argued that an approach which focuses on the most at risk of imminent hospital admission and thus on the most frail may not achieve the best outcomes.<sup>[29]</sup>

Even if we can accurately identify those with early frailty, what evidence is there that an intervention would improve outcomes? An example of the potential benefits comes from the Programme on Research for Integrating Services for the Maintenance of Autonomy (PRISMA) project.<sup>[30]</sup> This quasi-experimental study in Quebec used a score of 3 or above on the PRISMA-7 questionnaire to identify those at risk of loss of autonomy who would benefit from case management. Evaluations of the project suggest that it led to improved function and cost-savings related to reduced and less costly contact with health professionals.

### 2.8.2 The Electronic Frailty Index (Efi)

One method of identifying and grading the severity of the frailty is by using the 'cumulative deficit' model, which measures frailty on the basis of the accumulation of a range of deficits, which can be clinical signs (e.g. tremor), symptoms (e.g. visual impairment), diseases, disabilities and abnormal test values. Identification of these deficits enables calculation of a frailty index (FI) by dividing the number of deficits present by the total possible. This score is strongly predictive of adverse outcomes and has been validated in large international studies.

An electronic Frailty Index (eFI) has been developed and validated using the ResearchOne database. The eFI is based on the cumulative deficit model of frailty and

uses existing electronic health record data to calculate a frailty index score, so does not require any additional clinical assessment.

The eFI is made up of 36 deficits comprising around 2,000 Read codes (see Table 1 for list of 36 deficits) and is presented as a score (e.g. if 9 deficits are present out of a possible total of 36 the eFI score = 0.25).

Higher scores indicate increasing frailty and greater risk of adverse outcomes (e.g. on average, those with an eFI score >0.36 have a six-fold increased risk of admission to a care home in the next 12 months and a fivefold increased mortality risk, compared to fit older people).

The eFI is now available as a practice-level report in SystemOne (Reporting →Miscellaneous Reports →Electronic Frailty Index Report). Frailty scores are calculated for practice patients and presented as a list in descending order of frailty (most frail at top of list).

There are plans to: include the eFI as a protocol for use in the individual patient record, along with frailty categories (fit, mild frailty, moderate frailty, severe frailty); link the eFI to evidence based medication review checklists (e.g. STOPP/START criteria); release an eFI version that is compatible with other electronic health records (e.g. EMIS/VISION)

More information is available at <http://www.improvementacademy.org/improving-services/healthy-ageing.html>

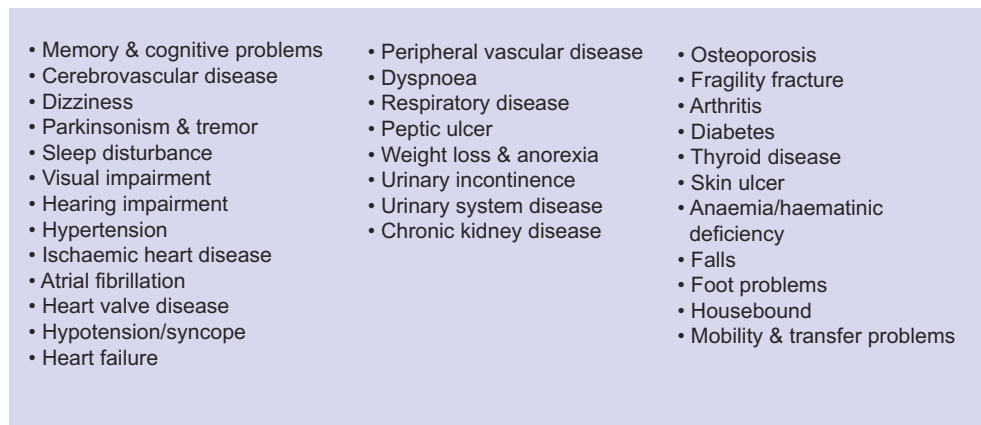
- 
- Memory & cognitive problems
  - Cerebrovascular disease
  - Dizziness
  - Parkinsonism & tremor
  - Sleep disturbance
  - Visual impairment
  - Hearing impairment
  - Hypertension
  - Ischaemic heart disease
  - Atrial fibrillation
  - Heart valve disease
  - Hypotension/syncope
  - Heart failure
  - Peripheral vascular disease
  - Dyspnoea
  - Respiratory disease
  - Peptic ulcer
  - Weight loss & anorexia
  - Urinary incontinence
  - Urinary system disease
  - Chronic kidney disease
  - Osteoporosis
  - Fragility fracture
  - Arthritis
  - Diabetes
  - Thyroid disease
  - Skin ulcer
  - Anaemia/haematinic deficiency
  - Falls
  - Foot problems
  - Housebound
  - Mobility & transfer problems

Figure 3: Deficits identified by Electronic Frailty Index

### What performance and outcome measures should we apply to services for people with frailty?

#### 3.1 Challenges of measuring cost effectiveness

Care of older people forms a large part of the health and care budget.<sup>[31] [32]</sup> Identifying frailty and developing services which have been of proven clinical effectiveness in terms of reducing adverse outcomes (which themselves are costly) is a step towards an approach which may result in cost savings. It has previously been demonstrated that there is considerable variation in unplanned admission and acute hospital bed use between commissioning authorities in England.<sup>[32]</sup> The available data appears to show a trend towards fewer emergency admissions in areas where there is better development of integrated services.

As yet it has not been possible to identify any area in the UK which has been able to reorganise the whole spectrum of services with cost savings. The reasons for this are complex.

Two issues need to be considered when evaluating service change. The first is the number of people to whom an intervention should be applied before a measurable effect on outcome may be validly identified. This is compounded when the intervention (in this case, holistic comprehensive assessment followed by individualised care and support planning and review) is used much less frequently than intended. Both the issues need to be considered when evaluating service change.

The process of evaluating innovative services which are intended to provide integrated solutions for older people with frailty is very complicated and often disappointing. Large scale reorganisations can lose sight of the fundamental clinical changes which are most likely to achieve the desired goals. It is therefore important to keep sight of these fundamental changes, plan for them and evaluate them separately and especially.

Specifically these may be:

- ▶ A system for recognising frailty and defining a pathway of care for each category of severity.
- ▶ A core cultural shift towards partnership working and respect for what is important to the individual living with frailty (in line with Francis and Berwick reports).
- ▶ Specific pathways which ensure access to holistic assessment and where needed, comprehensive geriatric assessment.
- ▶ Specific interventions to ensure access to programmes which reverse or ameliorate frailty.
- ▶ A system of care which is accessible for the older person and their carers/family and therefore improves satisfaction with care.

- ▶ A system of care which enables individualised care and support planning (CSP) for each individual with frailty.
- ▶ A system that ensures the care plans are available for any health and social care professional who needs to see them at the time they are needed.

## **3.2 Which measures of effectiveness might be most relevant for an older person living with frailty?**

### **3.2.1 Process measures of effectiveness**

- ▶ Numbers of frontline staff trained in the recognition and management of frailty
- ▶ Audits of the AUA DES (Avoiding Unplanned Admissions Direct Enhanced Service) re-framed to incorporate frailty and unmet patient needs
- ▶ Waiting time to be seen for CGA after an index event or recognition of frailty
- ▶ Delay in hospital awaiting an ‘assessment’ which could have been completed at home had an appropriate patient pathway been in place.

### **3.2.2 Outcome measures for older people and their carers**

- ▶ Self-Reported Quality of Life (e.g. EQ5D)
- ▶ Patient Activation Measures
- ▶ Patient and carer experience of health and social care services
- ▶ Patient safety and avoidance of harms such as falls, pressure sores, adverse drug reactions, deterioration in mobility.
- ▶ Place of death being as preferred
- ▶ Self-reported loneliness (e.g. de Jong-Gierveld loneliness scale)
- ▶ Self-reported pain (e.g. geriatric pain measure short form)
- ▶ Self-reported functional measures (e.g. Nottingham Extended Activities of Daily Living scale)

### **3.2.3 What Outcomes might we expect for the Health Service locally?**

- ▶ Reduction in excess bed days/delayed transfers of care
- ▶ Reduction in number of outpatient visits
- ▶ Reduction in number of primary care consultations
- ▶ Staff experience of care and satisfaction
- ▶ Reduction in patient harms (improved safety) which include pressure sores, hospital acquired infection, increased mortality, delirium and reduced mobility.
- ▶ Improved staff recruitment and retention – being supported to do things well is better for staff than working in situations which foster lower quality care.

Many of these indicators are already routinely measured as part of the Safety Thermometer in England, Wales and Scotland or the CCG outcome indicator set in England. For an indication of which measures routinely map to existing information, see Safe Compassionate Care for Frail Older People using an integrated care pathway <http://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf> .

### **3.2.4 Longer-term outcomes**

Although important, ultimate desired outcomes (such as reduced emergency

admissions, reduction in health and social care costs) may take some time to achieve and are unlikely to be seen in the immediate aftermath of a service or structural change. The reasons for this are discussed in full by the Nuffield trust study.<sup>[33]</sup> Making investment decisions based on unrealistic short-term outcome expectations is at best unwise and, at worst, an inappropriate use of public resources.<sup>[34]</sup>

However there are grounds for optimism; in their 2013 review of all published interventions which aimed to reduce hospital bed use, Philp *et. al.* concluded that, ‘Reducing unnecessary use of acute hospital beds by older people requires an integrated approach across hospital and community settings. A stronger evidence base has emerged in recent years about a broad range of interventions which may be effective.’<sup>[35]</sup>

### **3.3 Structural changes which are more likely to support services for frailty**

#### **3.3.1 Commissioning models**

Future commissioning will need to move away from activity based payment regimes towards capitation contracting which is driven by outcomes. Capitation based contracting essentially requires providers to deliver a set of agreed quality outcomes for a discrete population.

While integrating services for frailty does not require them all to sit within the same management structure, it is essential that all services are bound together within some form of integrated contractual framework since commissioning for community services in isolation is unlikely to be effective. This means that in England, commissioners need to consider new models of collaborative commissioning.

Ideas such as Alliance Contracting or Lead Provider arrangements should be explored with the key principle being that incentives are mutually dependent on delivery of the desired outcomes.

As new models of primary care emerge, it is possible that these will also sit within a collective contractual framework.

An additional component that will need consideration is the role of personal health and care budgets. These are well developed in social care and all those entitled to Continuing NHS health care are already entitled to a personal health budgets. The results of some of the pilots on personal health budgets are encouraging but it is still unclear how this will be applied in the context of people with frailty. Nevertheless it makes sense in developing more personal care to try to bring personal health and social budgets together to support the individual.

Commissioners have used local levers to enhance services for those with frailty in some areas. (For examples, See Appendix 1, Case Study 4, A Local Enhanced Service for People with Co-Morbidities in Tower Hamlets and Case Study Study 5, Using A CQUIN to promote the identification of frailty in Brighton).



### **3.3.2 GP Federations**

The establishment of GP Federations has also been shown in early adopter sites to be a powerful enabler of integration, service development and quality improvement within General Practice. They can provide a more coherent body for secondary care community outreach teams to engage with GPs in supporting education, peer learning, pooling the expertise and learning of GPs with specialist skills across the wider workforce and actively enabling infrastructure process developments more powerfully than at individual practice level. Many Federations have also been awarded contracts which offer patients access to a wider range of services outside the hospital : ([http://www.rcgp.org.uk/policy/rcgp-policy-areas/~media/Files/Policy/A-Z-policy/General\\_Practice\\_and-the\\_Integration\\_of\\_Care%20\\_An\\_RCGP\\_Report.ashx](http://www.rcgp.org.uk/policy/rcgp-policy-areas/~media/Files/Policy/A-Z-policy/General_Practice_and-the_Integration_of_Care%20_An_RCGP_Report.ashx)].

Over time federations could develop into organisations which include community care and aspects of specialist care, especially community geriatricians reaching into hospital and hospital-based services working outside. This theme has been expanded in the recent publication of the NHS England Five Year Forward View with the proposal for a ‘MultiSpecialty Community Provider’ among a number of potential models for innovation.<sup>[36]</sup>

### **3.3.3 Workforce flexibility**

The recent focus on targets for emergency care management has resulted in a rise in the number of hospital based staff of all disciplines looking after older people with frailty. It is increasingly recognised that achieving emergency targets will require better flow through hospitals, implying shorter lengths of stay and early supported discharge, as well as systems to provide safer alternatives to hospital admission when appropriate. This can only be achieved with the expectation that all staff, whether employed by an acute trust or a community service, will work along the whole pathway of care for older people with frailty. This idea has been promoted as part of the Future Hospitals Commission from the RCP.<sup>[23]</sup> For an example of how issues of workforce flexibility have been addressed in one locality, see the Southampton Case Study (Appendix 1, Case Study 3).

### **3.3.4 The need for the development of explicit clinical pathways**

It is apparent that service integration and personalisation is the right model of care for older people with frailty. This may or may not result in structural change. However the effectiveness of this model will be significantly enhanced with the creation of streamlined ‘pathways’ of care which facilitate navigation through whatever structures exist. Therefore the following pathways need to be developed in all localities.

#### **Referral pathways for specific frailty syndromes with varying degrees of urgency**

The identification of common frailty ‘syndromes’ in an individual should enable easy referral along an established system to address the issues needed, for example falls, cognitive impairment, reduced mobility.

#### **The creation of an easily accessible pathway to avoid hospital admission when clinically appropriate**

Keeping an older person with frailty at home during or after a crisis should be as straightforward as arranging hospital admission. The pathway will need to ensure that

there is an arrangement for making a diagnosis to explain the deterioration (which might involve the GP or rapid access to a Geriatrician) and adequately skilled health staff to provide ongoing supervision and support of the individual as they recover. Additional personal care support must be part of the pathway and should be free to the user (who would not have to pay for this if admitted to hospital).

The 'admission alternative' pathway must be accessible for a realistic period in the day, likely at least 14 hours a day and 7 days a week. To be a viable service it must be easy to access via a single point with timely responses to the older person and his/her carer. On occasion and in some localities, the alternative to admission might involve the use of 'step up' beds or other forms of intermediate care. Whilst accepting that this can offer a solution, the recent National Audit of Intermediate Care found that many of these units were run with limited medical cover despite accepting individuals with unstable illness (NAIC 2013 ref). It is unsafe and poor quality care to avoid hospital admission in a patient who clearly needs investigation to establish a diagnosis and/ or is unstable medically.

**A 'pull' pathway out of hospital so post-acute care does not happen in an acute hospital**

Although many of the health crises which affect older people with frailty could be managed in ways other than hospital admission, all older people need a diagnosis and sometimes acute intervention or treatment. Often this is most effectively delivered in hospital. Challenges to patient safety arise when the admission is poorly managed, resulting in delirium and failed diagnoses; prolonged stays resulting in deterioration in mobility, hospital acquired infections and further delirium as well as other harms; or followed by poorly managed discharge.<sup>[37]</sup>

Multi-disciplinary/multi-agency teams need to be working across primary, community and secondary health and social care to pull older people with frailty along a pathway of care and back into the community before, during and after a crisis. This can be achieved by provision of genuine alternatives to admission when this is appropriate; sharing information about care plans to shorten hospital stay when admission is needed, and effecting rapid hospital exit as soon as a patient is ready by providing a range of post-acute care which is readily available and accessible. No long term care planning should be done whilst someone is in an acute bed, and older people should have to stay in an acute bed only as long as they have an acute need.

**Managing continuing health care protocols to avoid clinically harmful delays**

Implementation of the current Framework for Continuing Health Care (CHC) in England and Wales in some areas, results in unacceptable delays in arranging hospital discharge whilst the necessary assessments which precede a decision about CHC eligibility are undertaken and refined.

Local pathways should be established to ensure that there is timely and regular assessment and review, in community settings, of individuals who have features which might demonstrate a primary health need. These features include intensive or complex care packages, frequent health crises and GP call outs, multiple outpatient appointments. If in those circumstances an individual does need an inpatient admission, the discharge need not be delayed (assessment for CHC having already been recently completed). In addition, local protocols should be put in place between Clinical Commissioning Groups (CCG) and Social Services Commissioners, which covers hospital admission and allows flexible and retrospective repayment.

It is poor clinical care, and risks significant harm to patients, to delay the discharge of a patient because of disagreements about responsibility for funding long term care placement. Local systems should be flexible enough to settle the patient and then organise the funding.

**Sharing of information around an individual's care and support**

It is clear that much information will be gathered around individuals with frailty. The format of an individual's care and support plan (CSP) will vary to reflect local arrangements and IT systems. However in order to ensure comprehensiveness and easy recognition, it is appropriate that the plans follow a consistent local pattern and are easily transferable between different IT systems. Ideally, it would be shared electronically with appropriate others (ambulance, social worker, emergency department etc.). However, even if this were always possible (which it is not currently), there is no guaranteed ability to access the appropriate health record when needed due to variable mobile internet access and the changeover of staff in all settings, meaning variable IT skills. A failsafe mechanism is likely to involve the older person keeping a hard copy in their own home, either in a standard place or a place which is known to those likely to be involved at a time of crisis. Local pathways are needed which determine the standard procedures for sharing information and for accessing others' notes.

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### Case Study 1

#### Warwickshire Age UK project – EASYCare approach

The increasing financial burden on health and care service provision combined with the global challenge of ageing populations requires new approaches to the way that societies, workforces, and health and care systems are structured. Services are becoming increasingly restricted to people with critical and severe levels of need, thereby reducing scope to provide low level support and advice.

The EASYCare approach has been developed over 25 years and has been found to be valid and reliable in different countries and cultures including those with poor, middle income and rich populations, with a diverse range of systems of funding and delivery of care. It offers a flexible, reliable and person-centred assessment which collects data directly from older people and mobilises a targeted response according to their priorities.

In South Warwickshire, one model that generated a high level of uptake is for GPs to invite patients aged 75+ to complete an EASYCare assessment with assistance from trained Age UK Co-ordinators and volunteers by telephone or face to face. Results are then used to signpost patients to further services, advice and support from a locally developed library of resources. Often, the most common problems identified, such as loneliness, are addressed through referrals to voluntary services, such as Age UK befriending support, rather than statutory services. The pilot had a response rate of over 50 per cent with users reporting high levels of satisfaction with the process and outcomes, with one user commenting, “I cannot believe I now have all this support resulting from a tick in a box. Aged 82 my life has changed...” A similar initiative based on this model is now being set up in Yorkshire.

By targeting and systematically identifying the needs and priorities of older people at an earlier stage using EASYCare methods, there is an opportunity to improve awareness of alternative sources of support and advice, which can often be found within the community and voluntary sector. This can help older people and their families to make an informed decision about addressing their health and care needs before they reach a crisis point and help prevent inappropriate contact with statutory services. Older people and their families feel empowered, whilst providers and commissioners benefit from access to a rich source of intelligence which can better help them to target resources and develop services.

Read more : [www.easycareproject.org](http://www.easycareproject.org)

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### Case Study 2

#### Gnosall Birthday card Project

In Gnosall surgery in the West Midlands, the Practice sends out a 75th birthday card to all its patients. Incorporating a self-assessment questionnaire, patients are invited to return the completed card to the surgery. The return rate is 75-80 per cent.

Using a locally developed scoring system, patients with frailty are identified and



visited by a care facilitator at home. They do a structured and complete history of the individual's social and medical care and complete the bulk of the information for the Holistic Assessment. The patients' carers with the care facilitators are invited for a clinical consultation at the practices where they are seen in dedicated surgeries using doctors employed specifically for this process. The doctors are a combination of local GPs with a special interest in frailty, retired doctors, consultants and GPs and local trainees who are awaiting the next step in their career pathway. They are asked to review the clinical data known and recorded in the primary care system in relation to the care facilitator information. This includes medicine management and outpatient reviews. They are asked to review all inputs against outcomes and to facilitate discussion about the patient's expectations of care for the future. This needs to be handled sensitively, requires a good doctor patient relationship and excellent communication skills. The outcome of these discussions determines the care plan. This describes the inputs and outcomes as well as costs of care for the individual.

The care plans are put in electronic format using a commercial electronic tool. They are also in paper format, bearing a window logo to alert the ambulance staff if they come in contact with the patient in question. The hard copy is kept in the patient's home. The document gives access to the GP notes and goes with the patient into hospital. The hospital staff therefore has access to the GP system and the community care plan.

As yet there are no quantitative outcomes available but this process is based on the Dementia pathway pioneered in the same practice. The Dementia pathway resulted eventually in the closure of hospital beds because of the resulting reduction in crisis admissions and the improvement in local communication and proactive care.

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### **Case Study 3**

#### **Workforce flexibility in Southampton**

Acute hospital care for older people in Southampton is managed by a team of consultants who are attached to a geographical locality reflecting GP clusters and community care teams, supplemented by an acute care case manager. They manage the care of older people from their locality who are admitted to the Medicine for Older People Department in University Hospital Southampton.

The early pilot showed a reduction in length of stay of over two days and this has been reflected since restructuring the department in a reduction in bed utilisation in the Trust despite approximately 4 per cent per annum growth in admissions.

Additional community staff have been employed to work alongside 'their' consultant in the hospital so as to facilitate the 'pull' of a patient out of hospital once the patient is fit for discharge. The same consultant can then look after the patient alongside the GP once the patient is at home (or in a post-acute care bed). If the patient is re-admitted, they will be looked after by this same consultant who then knows much of their previous history.

There has been increase in satisfaction from staff despite 'safari' ward rounds because of better continuity of care. Also anecdotal evidence from patients has shown they prefer the named consultant and continuity irrespective of recurrent admissions or ward moves.

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## Case Study 4

### Commissioning a proactive package of care for people with complex co-morbidities in Tower Hamlets

In Tower Hamlets a decision was taken some years ago that, for the major long term conditions, proactive care is best provided by resourcing a quality assured enhanced service in the form of carefully designed, detailed packages of care delivered within a framework of GP networks.

With increasing levels of co-morbidity we became aware of the significant burden of treatment and at times duplication within this disease-specific structure of care. Research into patient experience indicated that a person-centred approach was preferred. Clinicians were also concerned that the packages might be driving clinically inappropriate activities, for example chasing very tight glycaemic control in the very elderly person with type 2 diabetes. Finally, palliative care remained problematic; issues around death and dying tended to be raised too late for any effective planning or service delivery.

Starting in October 2013, we have been delivering a 'Coordinated Care Network Improved Service'. This was originally called 'integrated care for frail and/or complex patients' but this name was unacceptable to our older persons reference group who particularly disliked the word 'frail'.

Entry criteria are clinical, as the frailty score that we looked at failed to have the simplicity of the PRISMA 7. We include people with dementia, on the palliative care register, living in a care home, with heart failure (but we made a mistake by failing to specify severity) and then a discretionary group where practices were circulated a list of all their patients with multiple co-morbidities and asked to consider the following:

- Does this patient have significant limitation of function?
- Does this patient have significant psychosocial issues in addition to physical health problems?
- Is this patient likely to benefit from moving their care from their current services to a more generalist and holistic approach? (For example, some people are already well supported by specialist outreach teams such as HIV, learning disabilities, COPD services)

This is not based on admission risk scores (we use borough level GP and hospital data Q-admission scores) but most of this group fall into the higher risk groups, the main exception being people with dementia but who are reasonably well physically. This package covers about 2,500 people across Tower Hamlets (overall population about 290,000).

Recent qualitative research suggests that the people we have identified fall into three broad categories:

- Those people with frailty, largely dependent, already fully assessed and in receipt of packages of care/ care home resident
- Increasing frailty, trying to hold on to their independence
- Complex co-morbidities but functionally reasonably intact

The package requires the primary care teams to undertake assessment, or to collate information from other sources about function; this is collected using a questionnaire format derived from Dr David Reuben's work (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2822435/>) and is coded into the GP record where appropriate codes exist.

Some clinicians complete these with the patient but mostly they are completed in advance by the patient, often with input from their family and carers.

Screening questions for mood and memory problems are an integral part of the package and also, where needed, mental capacity assessment (this is an area which has highlighted a need for more competence and confidence).

Recent focus groups with Emergency Department staff from our local acute provider reported that some of the most useful information from the plans, when a person presents in crisis (after a fall or 'off legs'), are about social situation and baseline functional status.

GP teams are responsible for pulling together and streamlining delivery of all the processes of care that this person might need across the course of the year, taking account of the clinical and functional situation e.g. batching all the blood tests they need. Medication reviews consider appropriateness of prescribing and the balance of risk and benefit around polypharmacy for that individual, and local guidance for prescribing in the last years of life is commissioned.

All of this information is ideally processed in advance of a care planning meeting. The conversations in these encounters are led by what is important to the patient and themes around retaining independence/fears of becoming dependent. Problems with mobility and loneliness tend to be far more prominent than purely medical issues. The intention is to identify supports for the person and their carers to support self-management and there are very active awareness programmes across the borough drawing attention to the community and voluntary sector resources and services which could be of help to them. Family and carers are more commonly involved and indeed quite often we are working with a couple and need to think about the mutuality of their support for each other. By the end of August 2014, 61 per cent of all eligible people had completed this process.

We shifted our concept about palliative care to a framing around last years of life. This did open up conversations, for example around lasting power of attorney and advance decisions but both clinicians and patients struggle with this. One 88 year old said to the GP "...if I die".

It is very clear that this is an area needing a lot more development and training. The compassion in dying website has provided considerable support.

## **Community Team Development**

This general practice package is part of wider system redesign with redeployment and integration of community teams (the locality team now include community nursing, therapies, palliative care specialist nursing, case managers / care navigators, CPNs and social workers), roll out of record sharing, development of the Single Point of Access and practice based case discussion MDTs with community teams. However the most appreciated innovation from the GP point of view is the development of a community geriatrician role, providing not only direct clinical support but network level case-based peer learning sessions and other educational support.

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## **Case Study 5**

### **Using a CQUIN to promote the identification of frailty in Brighton**

In order to ensure that individuals with frailty are recognised and treated throughout the pathway of care, there needs to be a common language across providers and an integrated pathway of care. This is being achieved in Brighton through the use of a CQUIN for the acute provider and, in development, an enhanced service specification engaging both acute and primary care to establish complementary and consistent methods of assessment, care planning and communication.

#### **Pathway in Primary care**

To enable primary and community care to work differently and improve identification and support of individuals with frailty 24/7, there is a requirement to develop skills and workforce models. To support this along with other initiatives in development is an enhanced services specification which will look as follows:

##### ***Stage 1***

- Identify partners
- Establish joint/integrated working management and governance arrangements
- Quantify staffing and resource requirements
- Develop an education and development plan

##### ***Stage 2***

- Recruit staff/undertake necessary staff development and education
- Identify most frail and vulnerable patients (establish frailty register containing all patients over 75 plus those under 75 identified through case finding tools as at high risk of frailty i.e. in a care home, homeless, 3 or more long term conditions etc)
- Produce an evidenced based approach to case management and care co-ordination for frail and vulnerable patients
- Establish Multi-Disciplinary Team to co-ordinate care

##### ***Stage 3***

- Invite all patients on frailty register for a pre-assessment (self-assessment/telephone)
- Invite all high risk patients (identified through pre-assessment) for an initial needs assessment and identification of frailty score, follow up with a comprehensive assessment in the domains where needs are identified
- Invite appropriate patients for preventative consultation, support and care plan assessment or arrange a home visit

- Respond to hospital admission/discharge follow-up to review care plan
- Respond to advice calls from patient and carers (including other professionals) within 1 hour
- Provide a home visit (if required) and before 12 midday
- Develop plan for 7 day working, full case management and care co-ordination for identified cohort

**Pathway in Acute Care - the CQUIN mechanism has been used to deliver this as follows:**

- Improved quality of care for patients with frailty subject to internal ward transfers - to minimise non-clinically indicated internal transfers between wards.
- Assessment and interventions for patients identified as frail - to identify a cohort of patients who are identified as having “frailty” and needing optimal care and treatment when admitted to hospital urgently.

The CQUIN defines a list of quality standards/interventions including:

1. Use of agreed frailty screening tool
2. Completion of (or a planned date in place for) a comprehensive geriatric assessment
3. Estimated discharge date
4. Input from Allied Health Professionals/therapists from Day 1 to discharge
5. A personalised care plan that follows the patient following discharge to a community setting.

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## Case Study 6

### Using Age UK volunteers to promote participation in Cheshire

Age UK Cheshire has undertaken different streams of work to identify, locate and assist older people in Cheshire. The work is based around working alongside older people, their families and carers, identifying and then utilising their assets to improve outcomes.

They are working with Community Geriatricians, Primary Care workers and the Cheshire Fire and Rescue Service alongside the Department for Communities and Local Government in developing the capacity of Fire and Rescue Services around prevention and in promoting wellbeing.

Working in partnership with the Countess of Chester Foundation Trust, they are developing a new Frailty Hub which will focus on a local cohort of older people who are living with multiple long term conditions.

In order to facilitate their wider work around prevention and delivering tailored early interventions, they have developed a unique partnership with Cheshire Fire and Rescue Service (CFRS) called “Springboard”. This utilises access to the NHS Exeter Data spine in relation to those aged 65 and over. This data is then blended with diverse open data sets (see [www.opendata.gov](http://www.opendata.gov)). It is then put through profiling software and linked to GPS.

This innovative use of data and cross sector working enables the identification of those aged 65 and over across Cheshire. It also provides a level of insight into the circumstances of each household, for example, internet access, access to help putting out the refuse bins, use of oxygen and other aids.

The data on waste collecting service is “open data”. This identifies people who need their waste to be put out for them. Age UK Cheshire and the Fire Service then visit the individuals to uncover why they need that help. Perhaps they have osteoporosis or a condition that leaves them too weak to do this task. Age UK Cheshire and the Fire Service can then identify the services that this person may use and can set it in motion for them. In terms of access to residents’ homes, they have a 98 per cent success rate. One of the benefits of the project is that residents who have been struggling to manage, and who are unaware of help and supports available in the community, are connected to that support. The team undertakes around 20,000 visits per annum.

All of this work helps to assess needs of the older people who might have frailty, and provides practical support, thereby freeing up public services time.

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## Case Study 7

### Development of an Education Project for the Frailty Medical Workforce in the New Forest

In the New Forest, which has a very high population of older people, it is impossible for any one group of doctors to provide all the local medical services for frailty. Instead, a specialist frailty medical workforce is envisaged. This will comprise salaried and sessional GPs, including those employed by the local Community Trust, GP principals with an interest in frailty, Geriatricians and Old Age Psychiatrists in hospital and community care including those in training and Career Grade Staff in Geriatric medicine and community specialties. In order to ensure that the workforce is prepared to address the needs of older people with frailty locally, a joint education forum has been established. The purpose is to ensure that staff have the capacity to manage people in a variety of settings and situations including comprehensive care planning, safeguarding, promoting self-care and holistic assessment. The specific aims of the Forum are to:

- Share clinical expertise across the integrated care medical workforce and establish a list of essential competencies
- Increase knowledge and confidence in managing issues surrounding frailty in non-acute settings so as to support the achievement of basic competencies
- Share clinical problems and dilemmas so as to find high quality solutions for the local situation, hopefully leading to joint clinical pathway development.

The group meets twice monthly for an afternoon and topics covered include: recognising and managing walking and gait disorders in frailty; managing capacity and the need for Deprivation of Liberty safeguarding; the realities of Parkinson’s Disease



medication; and what to do about recurrent falls.

The expectation is to develop a list of specialist community frailty competencies to which those wishing to do this work will aspire.

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## Case Study 8

### The AGIS service in Cambridgeshire

The Acute Geriatric Intervention service (AGIS) is a collaborative venture between the East of England Ambulance Service (EEAST) and Cambridgeshire Community Services (CCS). It builds on the success of the Cambridge Falls Partnership Vehicle (FPV) which was a first responder ambulance jointly staffed by a paramedic and a member of the community team. The FPV had previously received a National Innovation Award for the services it provided and it was felt that this experience could be built upon. It was natural for the already established interdisciplinary team to progress towards providing a more comprehensive approach to healthcare provision. This includes interventions on long term conditions and the proactive case management of suitable patients in an acute situation.

The service facilitates two separate referral pathways, the first via 999 Emergency Ambulance Control for elderly fallers (AMPDS Code 17) and the sick elderly (AMPDS Code 26). The criteria for including these patients were that they were over 65 years of age and at their usual place of residence. The second referral pathway was GP direct referral. These patients were required to be over 75 years of age and at risk of admission to an acute healthcare facility but did not present with any red flag conditions, e.g. stroke or chest pain.

Governance for the service is provided primarily through a virtual ward round led by the Community Consultant Geriatrician, but also utilises case load supervision and case discussion with the patient's own GP. GPs are informed of all patient contacts and outcomes, excluding those admitted to an acute facility. This is either by letter following a contact or via telephone during any contact dependent on the nature of the situation. All decisions made for GP referrals were made in conjunction with the patients' GPs via telephone at the time. It is intended in the future to also hold bi-monthly clinical governance meetings to review practice.

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